

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Chesterton</u> LENGTH OF STAY (in this place) <u>20 years</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chesterton - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (First) <del>CARROLL</del> (Last) <u>THEODORE CARROLL</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>21</u> (Year) <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>2/24/1895</u>	
9. AGE last birthday <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry farm</u>		11. BIRTHPLACE (State or foreign country) <u>W.S.A. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>John T. Canall</u>			
14. MOTHER'S MAIDEN NAME <u>Charlotte E. Savin</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1918</u>			
16. SOCIAL SECURITY No. <u>221-20-4861</u>				17. INFORMANT AND ADDRESS <u>Mrs. Mary Canall - Chesterton Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420. Immediate cause (a) <u>Coronary thrombosis</u> - 5-10 minutes							
Antecedent cause(s) (b) <u>Coronary insufficiency</u> - several years							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Coronary arteriosclerosis</u> - several years							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-21</u> , 19 <u>56</u> , to <u>1-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-21</u> , 19 <u>56</u> , and that death occurred at <u>2 or 8</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Edgar L. Lane</u> M.D. <u>Chesterton Md</u>				DATE SIGNED <u>1-23-56</u>			
23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF <u>1-24</u>		NAME OF CEMETERY OR CREMATORY <u>Crompton</u>		LOCATION (City, town, or county) (State) <u>Crompton Md.</u>	
DATE REC'D BY LOCAL REG. <u>1-23</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane - Church Hill</u>		ADDRESS <u>Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 26 1956

RECEIVED

998

Reg. Dist. No. 251.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>Rural Barclay</u>	<u>6 Yrs.</u>	<u>Rural Marydel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>None</u>		<u>None</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Edward E. Daniels</u>		<u>1 12 56</u> 19	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>Col.</u>	<u>Widowed</u>	<u>3/21/1870</u>
9. AGE last birthday	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>85</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>Farmer</u>		<u>None</u>	<u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY?			
<u>U.S.A.</u>			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Simon Daniels</u>		<u>Mary Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>None</u>	
17. INFORMANT & ADDRESS:			
<u>Mary Daniels Barclay, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>422.1</u>			
IMMEDIATE CAUSE (A) <u>Acute Cardiac Dilatation</u>			
DUE TO			
ANTECEDENT CAUSE (S) (B) <u>Chronic Myocarditis</u>			
DUE TO			
(C) <u>Orbital Polypitis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Smoking</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>		<u>W</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
<u>No</u>		<u>At home</u>	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>None</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
<u>None</u>		<u>None</u>	
21F. HOW DID INJURY OCCUR?			
<u>None</u>			
22. I hereby certify that I attended the deceased from <u>Jan 12, 1956</u> , to <u>Jan 12, 1956</u> , that I last saw the deceased alive on <u>Jan 12, 1956</u> , and that death occurred at <u>530 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. E. Filicelli</u>		DATE SIGNED <u>Jan 12/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR ADDRESS	
<u>Burial</u>		<u>J. E. Boulois Greensboro, Md.</u>	
DATE THEREOF <u>1/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/14/56</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

EX-107

Walter Gordon  
Gordon  
Gordon

BUREAU V. S.

JAN 19 1956

RECEIVED

for 1956  
for 1956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

999

00978

Reg. Dist. 254

No. 257

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne's</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Queen Anne's</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Princess Anne</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Princess Anne P.A.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Thos.</u>	(Middle) <u>Edward</u>	(Last) <u>Stigdon</u>	(Month) <u>Jan</u> (Day) <u>17</u> (Year) <u>1956</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>May 6-1928</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>27</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>near Princess Anne Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Chas. C. Stigdon</u>		14. MOTHER'S MAIDEN NAME: <u>Belle Sparks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Sister Mrs Frances Lyon - Princess Anne P.A.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Very frail &amp; under nourished - died in an</u> DUE TO Antecedent cause(s) (b) <u>Epileptic seizure -</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>He was an imbecile, unable to walk or talk</u> <u>and an Epileptic</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER	
<u>W. Henry Fisher - Centerville Md</u>		DEPUTY MEDICAL EXAMINER	
		ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan. 19, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Centerville Cemetery</u>
LOCATION (City, town, or county) (State) <u>Centerville, Maryland</u>		24. FUNERAL DIRECTOR	
DATE REC'D BY LOCAL REG. <u>1-18-56</u>		REGISTRAR'S SIGNATURE <u>Helen Aldridge</u>	
		ADDRESS <u>Princess Anne, Maryland</u>	

RECEIVED  
JAN 25 1956  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

00979

No. 254

## 1. PLACE OF DEATH:

COUNTY Queen Anne's MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) LENGTH OF STAY (in this place)

TOWN Warr Queenstown

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Queen Anne'sCITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Queenstown R 70STREET ADDRESS (If rural, give location) 1

## 3. NAME OF DECEASED:

(First) Mary (Middle) E (Last) Larimore

(Type or Print)

4. DATE OF DEATH (Month) (Day) (Year) Jan 20 - 19 56

## 5. SEX:

Female

## 6. COLOR OR RACE:

White7. SINGLE, MARRIED, WIDOWED, DIVORCED

## 8. DATE OF BIRTH:

July 6 - 1879

## 9. AGE last birthday:

76 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): no10b. KIND OF BUSINESS OR INDUSTRY: Housework11. BIRTHPLACE (State or foreign country): Ireland12. CITIZEN OF WHAT COUNTRY? U.S.

## 13. FATHER'S NAME:

Fox

## 14. MOTHER'S MAIDEN NAME:

Don't know15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no16. SOCIAL SECURITY No.: none

## 17. INFORMANT &amp; ADDRESS:

James Reynolds Queenstown, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

## Immediate cause

(a) Found dead on floor of bedroom -  
DUE TO Exposure

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) no fire in house  
DUE TO no fire in house  
(c)

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

## SIGNATURE

W. Henry Fisher Centerville Md.CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 1/21-56  
DEPUTY MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAM. ☐

## 23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

## DATE THEREOF

Jan. 24-56

## NAME OF CEMETERY OR CREMATORY

St Peter's Church

## LOCATION (City, town, or county)

Queenstown

## (State)

Maryland

DATE REC'D BY LOCAL REG.

Jan. 24 1956

## REGISTRAR'S SIGNATURE

Helen M. Adredge

## 24. FUNERAL DIRECTOR

W. Evans Baker & Sons, Inc. Centerville Md.

## ADDRESS



DEPARTMENT OF HEALTH - BUREAU OF  
VITAL STATISTICS - BUREAU OF DEATH

BUREAU V. S.

JAN 27 1956

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OF HOSPITAL:** The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00980

1001

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>New York</u>		COUNTY <u>New York</u>	
CITY OR TOWN <u>Rural 1 Chestertown</u>		LENGTH OF STAY (in this place) <u>6 mos.</u>		CITY OR TOWN <u>New York</u>		69X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>1351 2<sup>nd</sup> Ave</u>		(If rural give location) <u>✓</u>	
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Helen</u>		(Middle) <u>Theresa</u>		(Last) <u>Neobegin</u>		(Month) <u>JAN</u> (Day) <u>28</u> (Year) <u>1956</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>MAY 28, 1904</u>	<b>9. AGE last birthday</b> <u>57</u> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>New York</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William Warner</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Agatha Webber</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>082-I4-203I</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Anthony Libersky, Chestertown, RI</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>156.1 IMMEDIATE CAUSE</b> (A) <u>Cancer of Liver</u>						<u>6 mos</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <u></u>							
<b>(C) <u></u></b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <u></u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>November 19, 1955</u>, to <u>Jan 28, 1956</u>, that I last saw the deceased alive on <u>Jan 27, 1956</u>, and that death occurred at <u>12:30 P.</u>M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>ACSEK</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Chestertown, Md</u>		<b>DATE SIGNED</b> <u>1-28-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE OF BURIAL</b> <u>Feb. 1, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Calvary Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>New York City</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Edgar L. Kane</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Willis Wells</u>		<b>ADDRESS</b> <u>Chestertown Md</u>	
<b>DATE</b> <u>1-31</u>							



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1002

00981  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 254

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Lewis Anne</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Lewis Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>near Luedentown</u>		<u>5 months</u>		TOWN <u>Wye Mills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Adam</u> (Middle) <u>Hamilton</u> (Last) <u>Reid</u>				(Month) <u>Jan</u> (Day) <u>21</u> (Year) <u>1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>		<u>Apr 5-1888</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Hardeman</u>		<u>Cottle</u>		<u>British Isles -</u>		<u>Scotland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Wm Reid</u>				<u>Mary Hamilton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>188-26-9598</u>		<u>Eliz S. Reid (wife) Wye Mills Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>W. Henry Fisher, Centerville Md</u>		M. D.		<u>1/23-58</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 24-58</u>		<u>Chesterfield</u>		<u>Centerville Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>Jan 24 58</u>		<u>Helen M. Adridge</u>		<u>W. Henry Fisher, Centerville Md.</u>			

RECEIVED

JAN 27 1956

BUREAU V. S.

1003

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Barclay</u>			
X TOWN <u>Rural Barclay</u>		84 Yrs.					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Herman Toulson</u>				OF DEATH: <u>1</u> <u>10</u> <u>56</u> <u>19</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, or Specified	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>Male</u>	<u>White</u>	<u>Specified</u>	<u>9/2/1871</u>	<u>84</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life.)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Truck driver</u>		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John M. Toulson</u>				<u>Francis O. Coleman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>None</u>		<u>Beulah Toulson Barclay, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Cardiac Deletations</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Chronic Myocarditis</u>							
(C) <u>Chronic Myocarditis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Smoking</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>0</u>		<u>—</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
<u>NO</u>		<u>at work</u>		<u>at work</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>10</u>							
22. I hereby certify that I attended the deceased from <u>Dec 26, 1955</u> , to <u>Jan 10, 1956</u> that I last saw the deceased alive on <u>Dec 26, 1955</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. E. Boulais</u>		M. D. <u>E. E. Boulais</u>		DATE SIGNED <u>1/11/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/13/56</u>		<u>Busie</u>		<u>Near Barclay, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1/12/56</u>		<u>Edgar L. Kane</u>		<u>E. E. Boulais</u>		<u>Greenboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Date Gordon's statement  
 Given to the  
 Commission  
 January

BUREAU V. S.

JAN 16 1956

RECEIVED

Jan 16 1956  
 [Signature]



## MARYLAND STATE DEPARTMENT OF HEALTH

00983

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

1904

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q.A.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Queenstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Jacob</u>	(Middle) <u>Henry</u>	(Last) <u>Wilson</u>
6. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 1, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oysterman</u>	9. AGE last birthday <u>32</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH WILSON</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE CARTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT AND ADDRESS <u>ANNIE CARTER - QUEENSTOWN MD</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Tubercular Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Coronary Heart Failure2 weeks

(c)

Hypertensive Arteriosclerosis C-V Disease2 yrs

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April, 1953, to Jan, 1956, that I last saw the deceased alive on Jan 7, 1956, and that death occurred at 12:48 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/11/56</u>	<u>Bryans Cemetery</u>	<u>Greenville</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan. 11 - 1956</u>	<u>Helen M. Aldridge</u>	<u>James B. Dashiell</u>	<u>Porton, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

JAN 13 1936

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1955

## CERTIFICATE OF DEATH

00984

Reg. Dist. No. 252

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Centerville</u>		<u>70 yrs.</u>		TOWN <u>Centerville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>ALEXANDER</u> (Last) <u>WOODROW</u>				(Month) <u>Jan</u> (Day) <u>13</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 15 - 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing &amp; Paperhanging</u>		11. BIRTHPLACE (State or foreign country) <u>Narrow Ontario Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Duncan Woodrow</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-3949</u>		17. INFORMANT & ADDRESS <u>Peale O. Woodrow - Centerville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>Cerebral Haemorrhage</u>						<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension Cardiovascular Disease</u>						<u>4 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial Infarction</u>						<u>4 days</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Coronary Failure</u>						<u>6 hrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 7</u> , 19 <u>55</u> , to <u>Jan 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>56</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>P. H. Lester</u>				ADDRESS (Street, city, town, state) <u>Centerville, Md.</u>		DATE SIGNED <u>1-15-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 15 - 56</u>		NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Oliver Armstrong</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hester</u>		ADDRESS <u>Centerville, Md.</u>	
DATE <u>1/14/56</u>							

BUREAU A. S.

JAN 20 1951

RECEIVED